Prescription Drug and Health Improvement Act of 2017
Senator Al Franken

Skyrocketing prescription drug costs continue to be a major driver of healthcare spending in this country, putting increased pressure on family and government budgets alike. Express Scripts, one of the nation's largest pharmacy benefits manager, reports that the most commonly used brand drugs have increased in cost by 208% since 2008.

Continually increasing drug costs impose an enormous burden on the federal budget. The HHS Office of Inspector General reports that spending on Medicare Part D catastrophic coverage increased by $22.4 billion from 2010 to 2015 with high-price drugs comprising 42% of Medicare Part D spending. The top ten high-price drugs contributed to almost one-third of catastophic spending in 2015 with monthly average price ranging from $8,673 for Xtandi to $33,811 for Harvoni.

High drug prices lead to higher patient costs, especially for seniors who fill on average more than 20 prescriptions each year. For example, Gleevec, which is used to treat a rare form of leukemia, has a wholesale list price of more than $120,000 for a year supply. Despite having health coverage, a third of Medicare patients prescribed Gleevec delayed initiation of treatment due to the exorbitant cost of the drug. Kaiser Family Foundation reports that the median out of pocket cost for Medicare beneficiaries for Gleevec was $8,500 annually. At these prices, many seniors, especially those on fixed incomes, are forced choose between purchasing their medicine and affording food or other necessities. More must be done.

The Medicare beneficiary population is one of the largest purchasers of prescription drugs in the country. The Congressional Budget Office (CBO) estimates that Part D spending will total $94 billion in FY2017. Yet, under current law, drug prices are negotiated directly between pharmaceutical companies and private insurance companies that contract with the government to deliver the Medicare drug benefit. This prevents the Department of Health and Human Services from leveraging the purchasing power of nearly 41 million Part D Medicare beneficiaries to get the best drug prices possible.

The Solution

To tackle rising drug prices, the Secretary of HHS must be given the power to negotiate with pharmaceutical companies on behalf of all Medicare beneficiaries. President Trump recently reiterated his support for this type of policy. Researches have estimated that the federal government could save between $16 and $24 billion annually if it could pay prices similar to those paid by Medicaid or the Veterans Health Administration. Americans have consistently supported this policy, with 83% of respondents in a recent Kaiser Family Foundation poll reporting support for Medicare price negotiations.

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This bill strikes the noninterference clause and gives the Secretary the authority to negotiate lower drug prices on behalf of the nation's seniors. Specifically, the legislation directs the Secretary of Health and Human Services (HHS) to negotiate prices for specialty drugs, drugs that that account for high levels of spending, and those with dramatic price spikes. The Secretary

may negotiate prices for a larger subset of drugs but must prioritize those that have the greatest potential to reduce spending. If, after a year, the Secretary and drug manufacturers have not successfully negotiated on a fair price, then Medicare Part D plans would be allowed to cover drugs at either the VA price or the price paid by the four largest federal purchasers of pharmaceutical drugs, including the Department of Defense and the Coast Guard. Nothing in this bill would prohibit Medicare Part D or Medicare Advantage plans from negotiating steeper discounts for seniors.

The legislation also includes provisions that would:

- Direct the Secretary to test various drug negotiation models based on emerging value-based purchasing arrangements. These models include:
    - Discounting or eliminating patient cost-sharing on high-value drugs and biologicals,
    - Value-based formularies,
    - Indications-based pricing,
    - Reference pricing,
    - Risk-sharing agreements based on outcomes,
    - Pricing based on comparative effectiveness research, and
    - Episode-based payments
- Require the Secretary to submit a report to Congress after 3 years and every subsequent 6 months on covered part D drugs including: how negotiations have succeeded in achieving savings, high spending on per beneficiary and high unit cost increases, spending on covered part D drugs with no therapeutic substitution, access to part D drugs, and appeals for drugs not included on plan formularies.
- Require MedPAC to conduct an evaluation of Medicare prescription drug negotiations, how they are achieving lower prices, and make recommendations for improvement.